Health Care for the Homeless

2222 Simon Bolivar Ave.
N. O., LA. 70113

1530 Gravier Street
N. O., LA. 70112

Registration Form

Has the patient received services at HCH before? □ Yes or □No

Patient's Information

Last Name _____ Sex: M F T
First Name _____ Middle _____
Date of Birth _____ Religion _____
Social Security Number: _____
Street Address _____
P.O. Box (if applicable) _____
City _____State _____ Zip _____
Home Phone ( ) _____
Cell Phone ( ) _____
E-mail address _____
☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Race and Ethnicity:
☐ American Indian/Alaska Native
☐ Asian ☐ White ☐ Multiple Races
☐ Black/African American
☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Native Hawaiian ☐ Pacific Islander
☐ Prefer not to answer.
Are you an Agricultural Worker? ☐ Yes ☐ No
Are you a Veteran ☐ Yes ☐ No
Occupation _____
Employer _____
Work Address _____
City _____ LA _____Zip _____
Work Phone ( ) _____
Employment Status: Full-Time ☐Part-Time ☐ None
Student Status: ☐ Full-Time ☐ Part-Time ☐ None
Primary Language ☐ English ☐ Spanish ☐ French
☐ Chinese ☐ Japanese ☐ Other _____
Housing Status: ☐ Street/Homeless ☐ Homeless Shelter
☐ Transitional ☐ Doubling up ☐ Institutional
☐ Permanently Housed, not Homeless
☐ Permanent Supportive Housing ☐ Unknown
☐ Public Housing ☐ Guste Homes ☐ Other _____

Parent Information (If patient is a minor.)

Last Name _____
First Name _____
Relationship to Patient _____
Date of Birth _____
Social Security Number _____

☐ Single☐ Married ☐ Divorced ☐Separated☐Widowed
Street Address _____
City _____ State _____Zip _____
Home Phone ( ) _____
Cell Phone ( ) _____
Email Address _____

Emergency Contact Information

Please list the name of a friend or relative that does not live with you that can be contacted in case of an emergency.

Name _____
Relationship to Patient _____
Phone _____
Address _____
City _____State _____ Zip _____

Insurance Information

First Policy:
Insurance Company _____
Phone # to Verify Coverage ( ) _____
Policy Number _____
Does your insurance need to be pre-certified? ☐ Yes ☐ No
Name of Insured_____

Second Policy:
Insurance Company _____
Phone # to Verify Coverage ( ) _____
Policy Number _____
Does your insurance need to be pre-certified? ☐ Yes ☐ No
Name of Insured _____

Other Insurance Information

☐ ***Medicaid (Please present your Medicaid Card.)***
☐ GNOCHC
Bayou Health Plan
☐ Amerigroup ☐ AmeriHealth Cartas
☐ Aetna Better Health
☐ Community Health Solutions
☐ Louisiana Healthcare Solutions
☐ United Healthcare Community Plan
☐ ***Medicare (Please present your Medicare Card.)***
☐ NONE
***Give Discount/Sliding Fee Scale Application.**

Office Use Only

Pt. # _____ Provider _____
Front Desk Clerk Entering Info in EHS_____
Date Entered _____ Time _____

11/01/2015